CASE REPORT

INTRAMYOMETRIAL ECTOPIC PREGNANCY

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Implantation of the embryo within the uterine musculature and surrounded entirely by the myometrium, remote from the endometrial cavity or interstitial part of the tube is intramyometrial or intramural ectopic pregnancy. We are reporting a case of intramyometrial pregnancy which occurred in one horn of a bicornis unicollis uterus.

CASE REPORT : 40 years, Mrs. S. L., G5P3A1L3 was refered to us on 27.6.96 from private clinic with H/o 3 months amenorrhoea and 2 failed attempts at MTP. The first dilatation & suction evacuation was done under LA on 13.6.96. She continued to have symptoms of pregnancy. An ultrasonic

Fig. 1. Coronal Section of a bicornis unicollis uterus with intramyometrial pregnancy. It shows intramyometrial gestation sac (hollow arrow), right nongravid (empty) endometrial cavity (large , solid arrow) and left nongravid (empty) endometrial cavity (small, solid arrow). Gestational sac is seen to the left of the left empty endometrial cavity.

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scan was done, which showed 8 weeks live, intrauterine pregnancy. A second dilatation & suction evacuation was done under GA, at which time no products were obtained despite a thorough curettage. Hence as USG scan was repeated, which showed a bicornuate uterus with 9 weeks, live pregnancy in the left horn. Adnexa was normal. On 27.6.96 when she attended our OPD, clinical findings were as follows - Besides the above history, patient also gave H/o menorrhagia for 2 years preceeding this pregnancy. Patient was clinically stable, speculum examination showed a single cervix with pregnancy changes and a normal vagina. On bimanual pelvic examination uterus was 12 weeks in size, soft, deviated to left & the right, firm, nongravid horn was also felt. Patient's haemoglobin was 11 gm%, CBC 7500; N60, L35, E5. Urine analysis, chest radiograph & ECG were normal. Patient insisted on hysterectomy in view of the 2 previous attempts at MTP & her past H/o menorrhagia. Transvaginal pelvic USG was performed at our centre. It showed an intrauterine pregnancy of 10.3 weeks, cardiac activity absent in the left horn of the uterus. Right horn showed decidual reaction. Abdominal scan showed normal maternal kidneys. Patient consented for a laproscopic guided suction evacuation SOS hysterectomy under GA. Laprosocpy showed a bicornuate uterus, right horn non gravid, both tubes & ovaries normal. Left horn soft, enlarged to 10 weeks size and it showed a bulge on the posterior aspect which left cystic. The suction curette was guided in the left gravid horn under laproscopic vision. No material was obtained from the cavity. The curette was guided towards the posterior soft bulge but it failed to dent the posterior uterine wall at the site of the bulge. A tentative diagnosis of intramural pregnancy of the left horn was entertained, and the patient explored by a midline, vertical, infraumblical incision. In view of her desire, consent and her past H/o DUB, a total hysterectomy was performed. Surgery was uneventful. The surgical specimen was sectioned in the coronal plane, as shown in fig. 1. The bicornis unicollis uterus on section showed two empty endometrial cavities. A gestational sac, intact, measuring 2½ cm in diameter, was seen to the left and in the posterior wall of the left horn ½ cm away from the left endometrial cavity, in the myometrium. Histopathology showed only decidual reaction in both endometrial cavities, no chorionic villi could be found. The sac had a 10 weeks foetus and trophoblast tissue. The sac was entirely surrounded by myometrium. No tract communicating from the sac to the left endometrial cavity could be dissected. There was no evidence of adenomyosis. The patient made an uneventfuly recovery.

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TWIN MOLAR PREGNANCY - A COMPLETE AND A PARTIAL MOLE

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Occurence of complete mole with normal fetus and partial mole with normal fetus is known. Its incidence varies from 1 in 10,000 to 1 in 100,000 pregnancies. But in this case there was combined complete and partial mole. Detailed search of medical lliterature failed to reveal a similar case.

A case 30 years of age was admitted to labour ward with history of 5 months amenorrhoea and scanty altered bleeding per vagina since 7 days.

I - Full term normal delivery at home 3 yrs back.

II - Present pregnancy.

On examination - BP - 140/90 mm Hg, Lower limb edema present.

R.S/CVS : Clinically normal.

P.A : Uterus 26 - 28 weeks, relaxed

Fetal parts not made out and fetal heart sounds not localised

A provisional diagnosis of molar pregnancy was made.

Ultrasound finding - Twin gestation - one sac revealing a mixed echogenic mass consistent with a complete mole and other with a single live fetus corressponding to 15 wks gestation and a normal placenta. No congenital anomalies were seen in the fetus.

Chest X-ray - Normal

A conservative line of management was decided to observe for growth of fetus and to judge the outcome. The patient developed severe pregnancy induced hypertension (BP 160/110 mm Hg, Urine alb +) and went rapidly into left ventricular failure 14 days after admission.

Hence labour was induced with prostaglandin gel and oxytocin.

Patient expelled a twin conceptus which was subjected to histopathology.

HISTOPATHOLOGY REPORT :-

Gross :- Specimen I consisted of multiple grape like vesicles amounting to 500 ml grey white and grey brown in color, larger vesicles measuring 3 cm in diameter. No fetal parts were made out.

Fig. 1.

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Specimen II consisted of male fetus with crown to rump length of 13 cm with attached umbilical cord and placenta. Placenta showed multiple grape like vesicles, larger vesicles measuring 1.5 cm in diameter. No fetal abnormalities were made out.

Microscopy from specimen I revealed features suggestive of complete mole.

Section from specimen II revealed features suggestive of partial mole.

The patient subsequently recoverd uneventfully.

AN UNUSUAL CASE OF POST MOLAR PREGNANCY

SHRIKANT BOLLAPRAGADA ● REENA WANI., M. Y. RAVAL

Mrs. D. a 26 year old housewife came to our out patient department with three months amenorrhoea, for a routine check up. She was a G3 P1 L1 A1. She had one full term normal delivery, male child who was 3 years old, alive & well. Her second conception was a vesicular mole for which she underwent suction evacuation at 16 weeks gestation, one year back at our institute. Following her vesicular mole evacuation she had followed up with us regularly for a period of six months & she had used barrier contraception during this period. Her serum β-hcg levels had become undetectable after 5 weeks and were negative ever since. Her clinical examination and chest x-ray findings too were normal.

Presently, she had no complaints and had come for a routine check up. Her general and systemic examinations were normal. On per vaginum examination, the uterus was twelve weeks in size, and soft. A routine pelvic sonography revealed a single intrauterine live gestation of 11 weeks 4 day. However her serum β-hcg levels were highly elevated & measured 5,00,000 MIU/ml.

Her pelvic & abdominal sonography was repeated & they confirmed the earlier findings with no evidence of any metastasis. However her serum β-hcg levels at 14 & 18 weeks were highly elevated at 6,00,000 & 4,00,000 MIU/ml. respectively.

The patient was closely monitored throughout her pregnancy. She did not develop any obstetric or medical complications. While her sonography findings were normal, her serum β-hcg levels remained elevated thoroughout her pregnancy.

She went into spontaneous labour at 39 weeks and had a normal delivery. She had a female child, weighing 2.9 kgs with a normal Apgar score. There were no intra-natal or post-natal complications.

Both mother and baby were discharged on 4th day & were advised regular follow up. She was also advised to undergo tubal ligation at a later date. Her serial serum β-hcg levels continued to a post-delivery and become undetectable after 4 weeks.

This is the first case where we have found serum β-hcg levels to be so unusually elevated in a normal post-molar pregnancy.

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NORMAL LABOUR PRECIPITATING SUBCONJUNCTIVAL HEMORRHAGE IN THE MOTHER

RANJANA SHARMA ● SANJIV DESAI

Subconjunctival hemorrhage occuring as a complication of labour has no precedene in literature to the best of the authors knowledge. Therefore a recent case is being reported. A 17 years old unbooked primigravida was admitted at our hospital with complaints of labour pains. She was anemic and her hemoglobin was 8.0 gm%. Her blood pressure stood at 130/90 mm. Hg. She progressed to an uncomplicated vaginal delivery and gave birth to a 3:2 kilogram weight live female child. After delivery it was observed by her attendents that both her eyes were deep red in colour and swollen. Occular examination revealed that the patient had developed bilateral subconjunctival hematoma with attendent chemosis. The fundii were ophthalmoscopically normal and so was the visual acuity (20/20 in both eyes). The bleeding and clotting times were within normal limits and the peripheral counts were normal. The patient was reassured and advised hot fomentation of the eyes for 10 minutes twice daily, for a week. After a 3 weeks there was gross reduction in the hemorrhages and after 5 weeks they had disappeared altogether.

Excessive straining, while coughing, vomiting or weight lifting has been known to produce subconjunctival and orbital hemorrhage. The strain produced while bearing down in labour increases the intra-abdominal and intra-thoracic pressure and consequently the pressure in the conjunctival vessels which may rupture and produce subconjunctival hemorrhage. This is the basis for the bilateral conjunctival hematomas observed in the present case. Although a benign condition, postpartum subconjunctival hemorrhage may be a source of great concern, indeed apprehension, to the patient if not recognised as such by the auxillary midwife nurse (ANM) or the medical officer. Reassurence with spontaneous resolution is the only treatment in such cases.

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CEREBRAL MALARIA IN PREGNANCY - SUCCESSFULY OUTCOME WITH ARTESUNATE DRUG

UMA DEVI ● ASHA SWARUP ● PADMA NANDINI ● SHEELA

Twenty year old Mrs. A who was a

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